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NAME OF	PROVIDER OR SUPPLIER				09/24/2010
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V 159	official systems of the subservations and at two day programments and integrations are also and integrations and integrations and integrations are also and integrations are also and integrations are also and integrations are also and integrations and integrations are also and also and also are also and also and also are also and also also and also are also and also also and also are also also also also also also also also	enditions of Participation re Services and Active urvey were based on erviews with staff in the home ams, as well as a review of tive records, including	W 159	July 10/15/10	
	Each client's active tr integrated, coordinate qualified mental retar	eatment program must be ed and monitored by a dation professional.			
; ; ;	based on observation review, the facility's qu professional (QMRP) coordination of service	es to promote the health the four clients residing in			
7	The findings include:				
N VROGN	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNAT	URF	Time	
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3015889287 04:23:48 a.m. 10-27-2010 PRINTED: 10/08/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WING 09G139 09/24/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 159 Continued From page 1 W 159 1. [Cross Reference W189 and W193] The 1. Staff will receive training on Client #3 QMRP failed to ensure all staff received effective 10/29/10 food texture requirements, Client #1 BSP training on the implementation of Client #3's food and proper documentation for his bowel texture requirements, Client #1's behavior support movement charts. plan and proper documentation of Client #1's bowel movements. 2. The nutritionist will provide training on 10/29/10 2. [Cross Reference W194] The QMRP failed to client's food texture. ensure all staff demonstrated competency in implementing a client's food texture requirements and implementation of a behavior support plan. 3. The psychologist will provide training 10/29/10 on-going training to all staff on Client #1 3. [Cross Reference W2525] The QMRP failed to BSP. The QMRP and House Manager will ensure that staff documented all incidents of review data on a daily basis to ensure staff Client #1's observed maladaptive behaviors. are accurately documenting behaviors. Failure to properly document all behaviors 4. [Cross Reference W436] The QMRP failed to will result in disciplinary action. ensure all clients received their recommended adaptive equipment. 4. QMRP and Nursing Staff will Implement 4. [Cross Reference W474] The QMRP failed to 10/29/10 recommendations for adaptive equipment. ensure all clients received their meals in the prescribed texture. 5. The facility's QMRP failed to ensure the 5. Daily meal observations will be 10/29/10 ambulation protocol was available and presented conducted by the QMRP/ Residential to all staff to ensure consistent implementation Menager to ensure that all individuals while assisting Client #2 while ambulating, as receive the prescribed texture. follows: 6. The QMRP and House Manager will Observation on 9/23/2010, at approximately 10/29/10 ensure Client #2 receives their

12:15 p.m., revealed Client #2 was wearing a loosely secured gait belt and a soft padded helmet. The helmet appeared to be properly fitted and the gait belt was loosely secured around his waist. During the observation, Client #2's 1-on-1 nursing staff (provided by the facility) used his left hand to hold the right side of Client #2's gait belt as he assisted him to ambulate

recommended adaptive equipment as well as ensures an ambulation protocol is in place. All staff will receive training on the current protocol as well as on-going training for any changes.

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 8YPV11

Facility ID: 08G139

If continuation sheet Page 2 of 26

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05:24:19 a.m. 10-15-2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/06/2010 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A BUILDING B. WING 09G139 09/24/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP GODE COMMUNITY MULTI SERVICES, INC 5610 FIRST STREET NW WASHINGTON, DC 20011 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ΙD (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) W 159 Continued From page 2 W 159 around the facility. On other occasions, he was observed holding to the back of Client #2's gait belt as he walked behind him. Later on the same day at approximately 4:20 p.m., Client #2 returned home from his day program. Upon exiting the van, the attending nurse and one of the van staff each grabbed under Client #2's armpits and assisted him up the stairs to the front door of the facility. The attending nurse was then observed to continue the hold under Client #2's left arm and assisted him up the stairs to his bedroom. Record review on 9/24/2010 at 12:08 p.m. revealed, Client #2's Physical Therapy assessment dated 08/03/2009 recommended that the facility continue the ambulation protocol. Further record review and interview with the QMRP on 9/24/2010, at approximately 3:00 p.m., revealed there was no documented evidence an ambulation protocol was drafted and on file for review. The QMRP also checked Client #2's habilitation records and confirmed that document was not on file. W 189 483.430(e)(1) STAFF TRAINING PROGRAM W 189 Cross reference W159 #2, #5 10/29/10 The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure all staff received training on the implementation of a client's food texture

and #31

requirement and behavior support plan, for two of the four clients residing in the facility. [Clients #1

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W 189	Continued From particular The findings include	ge 3	W.	89			
	employed staff received behavior support planel on 2/26/2010, evidence presented to substantiate that a staff received trainin "touch control" in manadaptive behavior in the factor of 1/24/2010, at appropriate than the 2/26/2010 med what was 2/26/2010 BSP training training.	ers. cility's house manager (HM) roximately 2:58 p.m., no other BSP trainings held 010 training. The HM further documented on the ng was true and a factual staff that attended the					
it ti ti ti ti ti	b/24/2010, at approxi- here was no docume he facility's ten (10) s lient #3's food texturo 9/1/2009. hterview with the facil n 9/24/2010 at appro- onfirmed none of the 10 staff) had received nodified food texture	W194] Record review on mately 2:45 p.m. revealed inted evidence that any of staff received training on re requirements dating back					

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сомми	NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011				24/2010
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W 189	Continued From page 4 staff training documents on hand to review.		W 189		Cross reference W159 #1		10/29/10
	The facility failed to	ensure all staff received					

The facility failed to ensure all staff received training on Client #3's modified food texture requirements to meet his developmental needs.

3. The facility failed to ensure that the direct support staff received training to ensure consistent documentation of Client #1's bowel movements, as follows:

[Cross Reference W331.3] On 9/23/2010, beginning at 2:54 p.m., review of Client #1's bowel movement (BM) charts revealed that direct support staff on each shift were instructed to enter a zero if he had no BM during their shift or use a symbol listed in the legend below the chart to document and describe every BM. [Example: H = Hard Stool (small rocks)] Continued review of the BM charts revealed numerous gaps where staff failed to provide data from their shift. Failure to document BMs during the past 3 months was noted on each of the three shifts.

On 9/24/2010, at approximately 12:35 p.m., the RN stated that she had provided training to staff on documenting clients' BMs on the BM chart. The RN agreed to seek training records for direct support staff and to contact the Director of Nursing to request evidence of training received by their nursing staff within the past 6 months. Review of staff in-service training records a short time later, beginning at approximately 2:55 p.m., failed to show evidence that the facility's nine (9) direct support staff and the house manager had received training on proper documentation of Client #1's BMs. No additional information was provided for review before the survey ended later that afternoon.

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	W 193	483.430(e)(3) STAF	F TRAINING PROGRAM	W 1	93	Cross reference W159 #3		400040	
		techniques necessa	o demonstrate the skills and ry to administer interventions propriate behavior of clients.					10/29/10	
		review, the facility fai and consistently impl	not met as evidenced by: n, staff interview and record iled to ensure staff accurately lemented a client's behavior r one of two sampled clients.						
		The findings include:							
	t t t a f h iii a b	Client #1 was observed irect care staff walked him to set the dinner response and remain Approximately, two more came very agitated the face and vocalize the eattempted to hit the he request of him to see the common of the dinner of the din	ed away. With clinched ining area and stood next to table. The direct care staff anager (HM) that she had the table and that he e request. About a minute at at the dinner table when himself on the side of his						

A short period of quiet passed (about three minutes) before Client #1 again became very agitated and got up from the table and approached the HM. He made three attempts to

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	open palm to preve Once the HM grabb himself to the floor a Both of his fists wer dining room floor ar loudly and also pour later the HM took C him to his seat at the remained agitated, woutil dinner was sense Record review on 9/12:05 p.m., revealed Plan (BSP), dated 10 following intervention behaviors: a. "Offer him a formation of the control of which activity which to do second, made a choice using b. "Use touch control abusive or hitting oth increase. Staff should another activity, whe work, staff may have control technique to go move him to anoth to physically prompt lactivity. Only staff whouch control proceduse this intervention."	grabbed his hands with an int herself from being hit. Died his hands, he lowered and laid there face down. The clinched as he lay on the ind he continued to vocalize inded on the floor. A minute lient #1 by his hands and led a dining table. Client #1 with no additional outbursts, wed. 124/2010, at approximately it client #1's Behavior Support it is address his targeted in the inside the inside the inside and choice once each day. The ean two objects, two rewards, if the choice can involve the ites or tasks to do first and etc. Reward the fact that he is descriptive feedback." If the screaming self items behaviors continue or indicate the propriate touch gently and quickly point him increactivity. Staff may have him to start doing the correct to have been trained in these cures and techniques should."		193	Cross reference W159 #2, #3		10/29/10
	someone, staff may t	e is continuing to try to hit at nave to physically take him					,

10-15-2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/06/2010 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER. COMPLETED A BUILDING B. WING 09G139 09/24/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW COMMUNITY MULTI SERVICES, INC. WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) W 193 Continued From page 7 W 193 Cross reference W159 #3 10/29/10 by the elbow and help him walk into another room and guide him to a chair. This is not enough. Staff should attempt to get him involved in some other distracting activity." d. "Create a "safety zone" if the aggression to others continue to escalate and he is disrupting the entire situation staff should either get him into another area or room or remove others from the area or room he is in." Interview with the facility's qualified mental retardation professional (QMRP) and HM on 9/24/2010, at approximately 12:30 p.m., confirmed the facility's staff failed to offer him "two choices" from the onset when he was initially asked to set the table. Further dialogue with the QMRP and the HM revealed the facility's staff also failed to physically redirect him to another activity, did not take him by the elbow into another room, and never established a "safety zone" for him in their effort to address his agitation and aggression. Client #1 was allowed to remain in the dining room the entire period he was agitated and was physically aggressive towards staff. The facility failed to demonstrate competency and accurate implementation of Client #1's behavior support plan to address his behavioral outburst and maladaptive behaviors. 2. [Cross Reference W252] A different team of staff had been observed working with Client #1

earlier that day (morning of 9/23/2010). Those staff failed to demonstrate competency in implementing his behavior support plan (i.e. documenting all incidents of targeted maladaptive behavior). Signature sheets for a behavior management training provided on 2/26/2010

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/06/2010 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER. COMPLETED A. BUILDING B WING 09G139 09/24/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW COMMUNITY MULTI SERVICES, INC. WASHINGTON, DC 20011 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETION PREEIX (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 193 Continued From page 8 W 193 Cross reference W159 #3 10/29/10 documented that the two staff on duty at the time of Client #1's morning behavioral outburst (screaming, hitting self and hitting Client #3) had been in attendance on 2/26/2010. W 194 483.430(e)(4) STAFF TRAINING PROGRAM W 194 All staff will be trained on all individual's 10/29/10 IPP goals. Management team will review Staff must be able to demonstrate the skills and IPP documentation weekly and staff will techniques necessary to implement the individual receive ongoing training on program plans for each client for whom they are documentation for all IPP goals. responsible. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the accurate implementation of program plans, for two of the four clients residing in the facility. [Clients #1 and #3] The findings include: 1. [Cross Reference W249.1] Staff working with Client #1 on the morning of 9/23/2010 falled to demonstrate competency in implementing the client's training program for learning to unbuckle his belt. 2. [Cross Reference W474] The facility's staff failed to demonstrate the skill and competency necessary to ensure Client #3 received all his meals in the texture prescribed to meet his developmental needs, as follows: Observation on 9/23/2010, at approximately 5:00 p.m., revealed staff served Client #3 his meal in a chopped texture, but failed to ensure the meal was served "mechanically soft" as prescribed by the primary care physician (PCP). Record review on 9/24/2010 at approximately 10:15 a.m.

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W 194	Continued From page		w	194	O			
	confirmed Client #3's current physician's orders (9/2010) prescribed he receive a "mechanically soft, chopped" textured diet.		-		Cross reference W159#1		10/29/10	
W 249	retardation profession approximately 6:10 phave provided Cilent textured meal as presented 483.440(d)(1) PROGAS soon as the intenformulated a client's each client must reconstruct treatment program conterventions and second frequency to suppression of the supp	p.m. confirmed staff should t #3 with a "mechanically soft" escribed by the PCP. BRAM IMPLEMENTATION disciplinary team has individual program plan, elve a continuous active	W	249	Cross reference W194		10/29/10	
	Based on observation review, facility staff fa programs and behaving recommended by the one of the two sample	not met as evidenced by: n, interview and record alled to implement training for support plans as interdisciplinary team, for ed clients. [Client #1]		•				
	The findings include:							
# t c t	Client #1 (who is non- #1 and stood in front on the client's belt while solient's means of inforuse the bathroom and and on the belt. After the	pproximately 7:34 a.m., verbal) walked over to Staff of him. The staff reached for stating that this was the ming him that he needed to I the client was unable to e staff unfastened the belt, s to use the bathroom. On						

05:26:25 a.m. 10-15-2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/06/2010 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER. COMPLETED A BUILDING B. WING 09G139 09/24/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY MULTI SERVICES, INC 5610 FIRST STREET NW WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 249 Continued From page 10 W 249 Cross reference W194 10/29/10 9/24/2010, at 3:59 p.m., review of Client #1's Individual Support Plan, dated 9/25/2009, revealed that he had a training program for him to learn to fasten and unfasten his belt. The plan stated that staff should provide "verbal prompts" and encourage him to unbuckle his belt. Observations revealed that staff working with him on the morning of 9/23/2010 failed to implement his program when the opportunity presented itself 2. [Cross Reference W193.1] Facility staff failed Cross reference W159 #2 10/29/10 to consistently implement Client #1's BSP. On the evening of 9/23/2010, Client #1 was observed hitting himself on the face and vocalizing loudly. He also attempted to hit a direct support staff. He repeated the behaviors several times until dinner was served. Record review on 9/24/2010, at approximately 12:05 p.m., revealed Client #1's Behavior Support Plan (BSP),dated 10/14/2009, revealed that staff should "Offer him a formal choice...physically redirect him to another activity...create a 'safety zone' if the aggression to others continue to escalate and he is disrupting the entire situation staff should either get him into another area or room or remove others from the area or room he is in." Observations, however, had revealed that staff

failed to offer Client #1 "two choices" from the onset, failed to physically redirect him to another activity, did not take him by the elbow into another room, and never established a "safety zone" for him in their effort to address his agitation and aggression. Client #1 was allowed to remain in the dining room the entire period he was acitated and was physically aggressive towards staff.

10-15-2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/06/2010 CENTERS FOR MEDICARE & MEDICAID SERVICES **FORM APPROVED** <u>OMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER COMPLETED A BUILDING B WING 09G139 09/24/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX TAG TAG DATE DEFICIENCY) W 252 483.440(e)(1) PROGRAM DOCUMENTATION W 252 Cross reference W159 #3 10/29/10 Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview and record review, facility staff failed to document all behavior data in accordance with the behavior support plan (BSP), for one of the two sampled clients. (Client #1) The finding includes: On 9/23/2010, at 8:06 a.m., Client #1 started shrieking foudly while seated next to Client #3 in the living room. Client #1 immediately turned to his peer and began striking him on his arm and shoulder. After a few short blows, the client began striking himself on his legs and he then stood up, still screaming. The behavioral outbursts lasted no more than 1 minute, in total. At the outset, Staff #2 responded by calling the client's name. The client quieted and immediately left the living room. Staff #1 stated that the client had been displaying similar behavioral outbursts for the past 3 days and would stay home from day program that day. [Note: The two staff present had been working overnight (12:00 a.m. - 8:00 a.m. shift). Staff #2 stated that he was staying for the next shift (8:00 a.m. - 4:00 p.m.),]

Later that day (9/23/2010), at 1:38 p.m., the house manager asked Staff #2 whether Client #1 had displayed any behaviors during his shift; he replied no." At approximately 5:30 p.m., review of

10-27-2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/06/2010 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB_NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER** COMPLETED A. BUILDING D WING 09G139 09/24/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY MULTI SERVICES, INC 5610 FIRST STREET NW WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {X5} **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION DATE TAG TAG W 252 Continued From page 12 W 252 Cross reference W159 #3 10/29/10 Client #1's BSP, dated 10/14/2009, confirmed that screaming, self abuse and hitting others were his primary targeted maladaptive behaviors. The BSP also instructed staff to document each of the behaviors "on the data sheets...in the IPP training book...At the end of the shift, one assigned staff person should determine, by asking other staff, the total frequencies of <client's name> behaviors." On 9/24/2010, at approximately 2:00 p.m., review of the client's behavior data sheets in the IPP training book revealed staff had entered "0" behaviors for the 12:00 a.m. - 8:00 a.m. shift and left blank the spaces for recording each of the three targeted behaviors. W 331 483.460(c) NURSING SERVICES W 331 The nursing staff will receive additional 11/2/10 The facility must provide clients with nursing training on physical assessment and services in accordance with their needs. documentation of findings. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure clients received nursing services according to their needs, for two of the four clients residing in the facility. [Clients #1 and #31 The findings include: 1. The facility's nursing staff failed to ensure that Client #1 received a timely medical assessment, as follows: On 9/23/2010, at approximately 11:50 a.m., Client

#1's day program activities coordinator stated that the client had hit himself and others while at the day program on 9/20/2010 and 9/21/2010. He had worked with the client since 2001 and he had only seen the client become assaultive when he

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was "impacted." He said that was the client's way to express pain or discomfort. The client stayed home on 9/22/2010, after the home agreed on 9/21/2010 to have him evaluated. [Note: The client returned to day program on 9/23/2010 with no communication received from the home documenting a physical examination.] Review of Client #1's behavior support plan (BSP) dated 10/6/2009, confirmed "constipation" was the first antecedent fisted for targeted behaviors of physical aggression towards others and self-injurious behaviors. On 9/23/2010, at 3:11 p.m., review of Client #1's primary care physician (PCP) notes revealed the most recent entry was dated 7/30/2010. The house manager (HM) stated that the client had an appointment scheduled with the PCP on the next day, 9/24/2010. Subsequent review of the client's Nurse's Progress Notes revealed entries dated 9/21/2010 at 5 p.m., 9/22/2010 at 7:30 a.m. and 9/23/2010. None of those three entries indicated that a nurse had assessed the client's abdomen and bowels during the three days. The above-cited nurse progress notes did reflect reviews of his BM habits on those dates. The client was taken to a hospital emergency room (ER) on the evening of 9/23/2010 due to "blood in the urine." The ER discharge report stated that lab testing failed to show blood in the urine. Further review of the ER discharge papers revealed no indication that any diagnostic procedures other than labs/blood in urine had been performed at the hospital. An entry made by the RN on 9/24/2010 at 7:40 a .m. reveled that "individual in no distress" and she had taken his vital signs. The entry, however,	

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W 331	aguanada i totti bai		W	331			<u>-</u>
	did not suggest an a abdomen was perfo	assessment of the client's rmed.		,,,,			
1	evaluation on 9/24/2 p.m., which was 3 di expressed concerns might be due to physically be du	at staff had documented BMs of 9/18/2010, evening shift of 9/18/2010, evening shift of shift of 9/21/2010, evening well as the morning shifts on 2010. Nursing staff, those BMs as evidence that pacted. In staff falled to ensure that preceived stool softener as cordance with his physician's ews: W368.3] On 9/23/2010, am activities coordinator in the client's bowel potential for fecal impaction. 9/2010 physician's orders ince 1/24/1994, he was to esia 400 mg/5 ml oral coby mouth every 3rd day as on if no BM." On 9/23/2010, and if no BM."			The facility's nursing staff will readditional training to monitor Bo Movement Charts and administed prescribed medication as ordered	wel er	10/24/10

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W 331	Continued From pa	ge 15	W	331			
	having administered (the 4th day), which	MOM at 7 p.m. on 9/9/2010					
	b. On 9/24/2010, at approximately 12:57 p.m., interview with the RN revealed that the evening medication nurse had been instructed to review Client #1's BM chart every 3 days and if there had been no BM, the nurse should administer the MOM, as needed. At approximately 3:20 p.m., review of the client's 9/2010 MAR revealed that the exact dates for said review by the evening nurse had been designated on the MAR every 3 days, beginning on 9/3/2010. The evening nurse documented having reviewed the client's BM chart on 9/3/10 but missed a review on 9/6/2010. The nurse documented a review on 9/9/2010 and 9/12/2010 but then missed a review on 9/15/2010. The evening nurse(s) falled to document a review of Client #1's BM chart every			m	he facility's nursing staff will be to conitoring Bowel Movement and ealth related information.		11/2/10
	medication orders, a	s follows:					
1	administered Client at (Synthroid) 50 mcg at The nurse said the closen changed approper the further stated the the Synthroid 30 minumedications. When a administered before this helps with absorption Administration and administration administratio	#3's Levothyroxine Sodium Ifter he had eaten breakfast. Ilient's Synthroid order had ximately 2 months earlier. orders were to administer utes before his other asked if it was to be food, the nurse replied "yes, ption." Review of Client #3's ation Record (MAR) for					

order to "30 minutes prior to breakfast" (previously had been "every morning") and the

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FOIR to the second of the seco	a.m. (previously had eview of the client's and 9/2010 failed to in his orders. In addeflect a change to his orders. In addeflect a change to his included only the previously written on the order by telephore order at the had received in the presented a hand gned that day (9/24 order read "30 minuted order, however, had the to it, with no indicate order or a medications listed orders were available or 9/23/2010, at 8:59 orning medication proposed." The POs included "Program or a presented or 4/15 a.m., the medication cabine or a predication cabi	d been changed from 7:00 d been 8:00 a.m.). However, a POs from 7/2010, 8/2010 show evidence of the change dition, the 9/2010 MAR did not now the order was written; it is typed order "every day" as a 7/2010 and earlier. Proximately 1:15 p.m., I revealed that she had taken the and she had changed AR to read "30 minutes prior request, the RN was unable adding physician's order. At a.m., the RN was asked again acall the approximate date of the telephone order. The diwritten order that was 1/2010 by the PCP. The less before breakfast." The che date 8/1/2010 written cation that it was a late entry as needed." It a.m., while verifying the ass observations, Client o'Air (Albuterol) HFA 90 ale 2 puffs every 6 hours as dicated that the Albuterol 1/4/2008; however, there for this PRN medication. At this pend stated that there is twice and stated that there	W	3331	The facility's nursing staff will extelephone orders are signed by a timely manner. The facility's staff will also notify the pharme orders to be included in the included in the physician order sheets.	y the PCP in nursing acy and new l	10/29/10
wa	a un winnisioi 9A9III	able. He suggested that it					

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W 331	Continued From pa	ge 17	W 33	31		
	find an order to disc approximately 10:5: qualified mental ret- and the HM indicate reason why Client # The QMRP immedi Assessment dated review, stated that s PRN medication.	continued; however, we did not continue the medication. At 5 a.m., the recently-hired ardation professional (QMRP) at they were not aware of any 13 might need to use Albuterol. ately presented a Medical 11/27/2009, and upon its she saw no indications for the		The nursing staff will receive train reviewing physician's order sheet telephone orders and ensuring all prescribed medications are avails primary nurse of this facility will be requested to provide written door and that MAR's and POS's are reand updated on a weekly basis.	ible. The entation	11/2/10
	recently-hired RN st typically prescribed indicated that she w Albuterol PRN was POs. She replied "r medication nurse ha for it on the previous p.m., the RN indicat informed her the Alb back at the time it w	pproximately 1:00 p.m., the tated that Albuterol was for treating asthma. She was previously unaware that prescribed PRN on Client #3's no" when asked if the ad informed her of his search is day. At approximately 2:20 and that the PCP had just puterol had been needed only was ordered in 2008. She then witten order to discontinue the at day by the PCP.				
W 340	and medical team re with the medications medications prescril	nce that the facility's nurses econciled physician's orders s-on-hand to ensure that bed for PRN use readily n needed by the client RSING SERVICES	W 34	0		
	other members of the appropriate protection measures that include the control of	ust include implementing with the interdisciplinary team, we and preventive health de, but are not limited to staff as needed in appropriate methods.				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES.

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W 340	Continued From pa	ge 18	W	340	Cross reference W159 #1		10/29/10
	Based on interview facility's nursing sta that staff had been document bowel modients in the sample. The finding includes	, 5 :			The direct support staff will readditional training on monitoric		10/29/10
	The facility's nursing direct support staff Client #1's BM's, as As noted above, Cli revealed "chronic codiagnosis. He received aily. The POs also 400 mg/5 ml oral sumouth every 3rd day no BM." On 9/23/20 review of the client's direct support staff to enter a zero if he or use a symbol listic chart to document a [Example: H = Hard Continued review of numerous gaps whe from their shift. Failst the past 3 months with shifts, as follows: a. 12 a.m 8 a.m. sentries on 7/1/2010, 8/2/2010, 8/5/2010 as b. 8 a.m 4 p.m. shifts	g staff failed to ensure that consistently documented follows: ent #1's POs dated 9/2010, constipation" as an ongoing wed Miralax and prune juice included "Milk of Magnesia spension, give 45 cc by as needed for constipation if 10, beginning at 2:54 p.m., as BM charts revealed that on each shift were instructed had no BM during their shift and describe every BM. Stool (small rocks)] I the BM charts revealed ere staff falled to provide data are to document BMs during was noted on each of the three whift - staff failed to make 7/26/2010, 8/1/2010,				ng and The the cord that	10/29/10

05:28:50 a.m. 10-15-2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/06/2010 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY COMPLETED A BUILDING 8 WING 09G139 NAME OF PROVIDER OR SUPPLIER 09/24/2010 STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY MULTI SERVICES, INC 5610 FIRST STREET NW WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION TAG DATE DEFICIENCY) W 340 Continued From page 19 W 340 7/19/2010. 7/22/2010, 7/23/2010, 8/6/2010, 8/31/2010, 9/1/2010, 9/14/2010 and 9/23/2010; and. c. 4 p.m. - 12 a.m. shift - staff failed to make entries on 7/31/2010, 8/1/2010, 8/6/2010, 8/14/2010 and 8/15/2010. On 9/24/2010, at approximately 12:35 p.m., the RN stated that she had provided training to staff on documenting clients' BMs on the BM chart. The RN agreed to seek training records for direct support staff and to contact the Director of Nursing to request evidence of training received by their nursing staff within the past 6 months. Review of staff in-service training records a short time later, beginning at approximately 2:55 p.m., failed to show evidence that the facility's nine (9) direct support staff and the house manager had received training on proper documentation of Client #1's BMs. No additional information was provided for review before the survey ended later that afternoon. W 368 483.460(k)(1) DRUG ADMINISTRATION W 368 The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that all drugs were administered in compliance with the

The findings include:

physician's orders, for three of the four clients residing in the facility. (Clients #1, #3 and #4)

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i i i p	1. [Cross Reference #3 was administered (Synthroid) 50 mcg: Interviews and reviee however, revealed the administered "30 minenhance absorption. 2. On 9/23/2010, Clief receiving his medica 9:26 a.m. At 9:27 a. documented the folio Medication Administration Thypotears 1% one of this a.m." After the note on the sam." After the note of the sam. The same same same same same same same sam	e W369] On 9/23/2010, Client d Levothyroxine Sodium after he had eaten breakfast. W of physician's orders (POs), hat the medication should be nutes prior to breakfast" to ent #4 was observed tions between 9:11 a.m m., the medication nurse owing on the client's ration Record (MAR): drop in each eye not available nedication nurse finished a on with the Director of , he looked again in the nute declared "found itit was ations. By then, however, facility; therefore, he was not obears (for dry eyes) in POs. In the declared that Client #1 stool softener as needed in, in accordance with his extractional procession of the proposition	W	368			

and self-injurious behaviors.

behaviors of physical aggression towards others

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/06/2010 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER COMPLETED A. BUILDING B. WING 09G139 09/24/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY MULTI SERVICES, INC 5610 FIRST STREET NW WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) **PREFIX** (X5) COMPLETION PREFIX TAG 1AG DEFICIENCY) W 368 Continued From page 21 W 368 Cross reference W331 11/2/10 On 9/23/2010, Client #3's medical records were reviewed upon return to the facility, beginning at 1:40 p.m. His Medical Assessment, dated 8/27/2010 and his POs 9/2010 revealed "chronic constipation" as an ongoing diagnosis, for which he received Miralax 17 grams dissolved in water daily (since 12/9/2009) and prune juice 6 oz by mouth twice daily (since 1/24/1994). The POs showed that since 1/24/1994, he was to receive "Milk of Magnesia 400 mg/5 ml oral suspension, give 45 cc by mouth every 3rd day as needed for constipation if no BM." Beginning at 2:54 p.m., review of Client #1's MARs along with a review of the client's Bowel Movement (BM) charts revealed that he had gone without a documented BM on 7/22/2010, 7/23/2010 and 7/24/2010 without receiving the PRN Milk of Magnesia (MOM). The BM chart for 9/2010 showed no documented BM on 9/6/2010, 9/7/2010 and 9/8/2010. A nurse documented having administered MOM at 7 p.m. on 9/9/2010, which was not in accordance with the POs. W 369 483.460(k)(2) DRUG ADMINISTRATION W 369 Cross reference W331 11/2/10 The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that all drugs were administered without error, for one of the four clients residing in the facility. [Client #3] The finding includes: On 9/23/2010, the survey started at 6:46 a.m., at

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& MEDICAID SERVICES			PRINTED: 10/06/20
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s, Inc	00	TO FIRST STREET NW	09/24/2010
EMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO-	
d that Client #3 had already and cleared his place Staff #1 turned to his that he just remembered "starting today," they were eakfast until after he edication was to be see before his other stast. Staff #1 further that provides Client #2 1:1 the pill at 7:00 a.m. and a d arrive at 7:30 a.m. to eations to Client #3 and his stered Client #3's (Synthroid) 50 mcg. The seived the medication to oppoximately 2 months had been changed to a 30 minutes before the n asked if it was to be d, he replied "yes, this Review of Client #3's on Record (MAR) for written change in the or to breakfast" and the on changed from 7:00 previously).	W 369	The facility's nursing staff will provide training for staff on Client # medication protocol for Synthroid.	3 10/29/10
	Dentification Number. 09G139 INC EMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL DENTIFYING INFORMATION) 222 In that Client #3 had already and cleared his place Staff #1 turned to his that he just remembered 'starting today." they were eakfast until after he edication was to be es before his other that provides Client #2 1:1 the pill at 7:00 a.m. and a d arrive at 7:30 a.m. to ations to Client #3 and his 1:1 nurse brought him stered Client #3's Synthroid) 50 mcg. The seived the medication to oproximately 2 months had been changed to 1:30 minutes before the n asked if it was to be d, he replied "yes, this seview of Client #3's on Record (MAR) for written change in the r to breakfast" and the n changed from 7:00 previously).	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER. 09G139 B WING STR SERVING EMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL DIDENTIFYING INFORMATION) EMENTIFYING INFORMATION TAG 22 Indicated the place Staff #1 turned to his that he just remembered 'starting today," they were eakfast until after he edication was to be es before his other stast. Staff #1 further that provides Client #2 1:1 the pill at 7:00 a.m. and a difference at 7:30 a.m. to ations to Client #3 and his 1:1 nurse brought him stered Client #3's Synthroid) 50 mcg. The selved the medication to oproximately 2 months had been changed to 130 minutes before the m asked if it was to be d, he replied "yes, this Review of Client #3's on Record (MAR) for written change in the r to breakfast" and the m changed from 7:00 ., previously). 19/24/2010, at interview with the QMRP	## MEDICAID SERVICES XI) PROVIDER/SUPPLIERCLIA DENTIFICATION NUMBER. A BUILDING

DEP CEN	ARTMENT OF HEALTI	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 10/06/2010 FORM APPROVED
SIAIE	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) N	IULTIPLE CONSTRUCTION	OMB NO. 0938-039
				LDING	COMPLETED
NAME (OF PROVIDER OR SUPPLIER	09G139	B. WI	YG	09/24/2010
1	MUNITY MULTI SERVICE	es, inc		STREET ADDRESS. CITY. STATE, ZIP (5610 FIRST STREET NW WASHINGTON, DC 20011	CODE
(X4) I PREF TAG	REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C	ON SHOULD BE COMPLETION JE APPROPRIATE DATE
W 36	ordered 8/1/2010, a survey.	lmost 2 months prior to this	W 3		,
VV 43	16 483.470(g)(2) SPAC		W 4	Cross reference W159	#4 10/29/10
	choices about the us hearing and other co and other devices id interdisciplinary tean	n as needed by the client.			
	review, the facility fail	not met as evidenced by: n, staff interview and record led to ensure all clients re equipment as prescribed ad clients. [Client #2]			
	The finding includes:				
	bed to sleep on. Reci 12:07 p.m. revealed, (assessment dated 08/ he receive a "helmet v	lient #2 wore a soft padded I was provided a hospital ord review on 9/24/2010 at Client #2's Physical Therapy (03/2009 recommended that with a face guard" and		The QMRP and the primary in review all recommendations for Speech Pathologist to identifor any adaptive equipment or basis. The padded rail and he face guard will be obtained.	rom OT, PT litify the need n a monthly
W 474	Interview with the facili retardation professions 12:10 p.m. confirmed to guard" and the "pads" hospital bed need edto 483.480(b)(2)(iii) MEAL	al (QMRP) on 9/24/2010 at he 'helmet with a face for the side ralls on his be purchased	W 474		
		a form consistent with the	** 717		

10-15-2010

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/06/2010 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER** COMPLETED A BUILDING B WING 09G139 09/24/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5810 FIRST STREET NW** COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID m PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) W 474 Continued From page 24 W 474 Cross reference W159 #2, #5 10/29/10 developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure all clients received their meals in the form and consistency as prescribed for one of the four clients residing in the facility. [Client #3] The finding includes: Observation on 9/23/2010 at approximately 5:00 p.m. revealed Client #3 was served a meal consisting of tortilla, grilled chicken, re-fried beans, lettuce, tomato, raspberry sherbet, milk and water. Client #3's tortilla, chicken, lettuce and tomato were served chopped. His re-fried beans were mashed and served soft. The milk and water were not altered and served accordingly. During dinner, Client #3 was observed taking large spoons (tablespoon) of food into his mouth. He was also observed not consistently chewing his food as he ate his meal. The facility's qualified mental retardation professional (QMRP) stepped in and advised staff to take the larger spoon away and to provide him with a smaller spoon (teaspoon). Client #3 continued to eat his meal, but this time he ate at a faster pace, seemingly to accommodate the use of the smaller spoon. His attending staff (1:1) provided touch control and asked him to slow down and put down his spoon. Record review on 9/24/2010 at approximately 10:15 a.m. revealed Client #3's current physician's orders (9/2010) and nutritional (1/2010) assessment identify he has been

prescribed to receive all foods in a "mechanically

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2010 FORM APPROVED OMB NO 0938-0391

		& WEDICAID SERVICES				OMB N	O. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				(3) DATE SURVEY COMPLETED	
		09G139	B. Wil	NG_		09	/24/2010
	NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC		<u></u>	!	REET ADDRESS. CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011		7,20
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD RE	(X5) COMPLETION DATE
W 474	Continued From pa soft - chopped" text		W	174	Cross reference W159 #2, #5		10/29/10
	retardation profession approximately 6:10 prescribed a "mecholisted on his 9/2010 QMRP also confirm Client #3 with a "meas prescribed by the (PCP). The facility's staff far and competency neighbor 1:00 profession approximately 6:10 prescribed a "mecholisted on his 9/2010 QMRP also confirm Client #3 with a "mecholisted on his 9/2010 QMRP also confirm Client #3 with a "mecholisted on his 9/2010 QMRP also confirm Client #3 with a "mecholisted on his 9/2010 QMRP also confirm Client #3 with a "mecholisted on his 9/2010 QMRP also confirm Client #3 with a "mecholisted on his 9/2010 QMRP also confirm Client #3 with a "mecholisted on his 9/2010 QMRP also confirm Client #3 with a "mecholisted on his 9/2010 QMRP also confirm Client #3 with a "mecholisted on his 9/2010 QMRP also confirm Client #3 with a "mecholisted on his 9/2010 QMRP also confirm Client #3 with a "mecholisted on his 9/2010 QMRP also confirm Client #4 with a "mecholisted on his 9/2010 QMRP also confirm the province of his	collity's qualified mental conal (QMRP) on 9/23/2010 at p.m. confirmed Client #3 was anically soft - chopped diet" as physician's order sheet. The ed staff should have provided echanically soft" textured meal e primary care physician eled to demonstrate the skill cessary to ensure Client #3 is in the texture prescribed to ental needs.					

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PRINTED: 10/08/2010 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/GLIA MBER:	(X2) MULTIP A BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
	HFD03-0044		B WING_				
NAME OF PROVIDER OR SUPPLIER	, , , , , , , , , , , , , , , , , , ,	STREET AD	DRESS. CITY. S	TATE, ZIP CODE	1 09/	24/2010	
COMMUNITY MULTI SERVIC	ES, INC		ST STREET N STON, DC 20				
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	CHI I	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
1000 INITIAL COMMEN	ITS		1 000 '				
A re-licensure surv 9/23/2010 through	ey was conducted fro 9/24/2010.	m	1 4				
from a residential progress of survey were based interviews in the hoas well as a review	g of two residents was population of four male disabilities. The findir on observations and ome and at two day property of the resident and ords, including the incidents.	es with ngs of the rograms,					
proper feeding tech	I train the staff in the uniques and monitor the	Jse of neir		All staff will be trained on all and food texture.	individuals diets	10/29/10	
Based on observati review, the Group H Retardation (GHMR residents received t	met as evidenced by: on, staff interview and fome for Persons with tP) failed to ensure all their meals in the form cribed for one of the f lity. [Resident #3]	Mental and					
The finding includes	: :		į				
p.m. revealed Resid consisting of tortilla, beans, lettuce, toma and water. Resident and tomato were set beans were mashed and water were not a	3/2010, at approximate lent #3 was served a rigrilled chicken, re-friento, raspberry sherbet, times to the transfer of tra	neal ed milk lettuce fried milk	· · · · · · · · · · · · · · · · · · ·				
RATURY DIRECTOR'S OR PROVIDE	ROLL REPRESENTA	PLANTIVE'S SIGNA	nan	Duette	10/	XB) DATE	

Health	Regulation Administra	ation				LOWN	MEEROVED
	NT OF DEFICIENCIES FOR CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE SI COMPLE	
NAME OF	DECLEDED OF PURPLES	HFD03-0044				09/2	<u>4/2010</u>
NAME OF	PROVIDER OR SUPPLIER			RESS, CITY. ST			
COMMI	JNITY MULTI SERVICE	S, INC	5610 FIRS WASHING	T STREET NO TON, DC 200	<i>N</i> 111		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETE DATE
1 055	Continued From pa	ge 1		1 055			***********
	food into his mouth consistently chewin The facility's qualific professional (QMRI staff to take the larghim with a smaller s #3 continued to eat at a faster pace, secuse of the smaller s (1:1) provided touch slow down and put of Record review on 9/10:15 a.m. revealed physician's orders (1/2010) assessment	724/2010 at approxima Resident #3's curren 9/2010) and nutritiona nt identify he has been e all foods in a "mech	red not nis meal. rised o provide esident e he ate date the staff im to				
	approximately 6:10 pwas prescribed a "mdlet" as listed on his sheet. The QMRP a have provided Resid soft" textured meal a care physician (PCP)	MRP on 9/23/2010, and the confirmed Residue chanically soft - cho 9/2010 physician's or also confirmed staff stated at the prescribed by the policy.	dent #3 ppped rder nould nically rimary				
	and competency ned	essary to ensure Reseals in the texture pre	sident	!			
1 090	3504.1 HOUSEKEEF	PING	1	090			İ
ith Basels	The interior and extermaintained in a safe, and sanitary manner accumulations of dirt	clean, orderly, attractand be free of	tive,				į

110011111	requiation Administ	i autori					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		R/CLIA MBER:	A. BUILD				
		HFD03-0044		B WING		na	/24/2010
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	RESS, CIT	RESS, CITY, STATE, ZIP CODE		
COMMU	NITY MULTI SERVIC	ES, INC	5610 FIRS WASHING				
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES FACH DEFICIENCY MUST BE PRECEDED BY FULL IGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
1 090	Continued From p	age 2		1 090	Client #3 closet ceiling will I	oe repaired.	10/29/10
	odors.						J [::::::::::
	Based on observal Home for Persons (GHMRP) failed to GHMRP was main	t met as evidenced by tion and interview, the with Mental Retardati ensure the interior of tained in a safe, order for four of four resider #1, #2 #3 and #4)	Group on the Iv. and				
	The finding include	es;			!		
	on September 23, The ceiling in a clowater damage. The and the qualified me who had accompanion	e environment was co 2010, beginning at 11: set located in bedroon e quality assurance as ental retardation profe nied the surveyor, conf oximately 1:00 p.m.	45 a.m. n #3 had ssistant essional.				
l 161	3507.2 POLICIES	AND PROCEDURES		l 161	CMS Policies and Procedures		10/8/10
	The manual shall b body of the GHMRI least annually.	e approved by the gov P and shall be reviewe	reming d at		reviewed and signed by Progr	am Director.	
	Based on record representations and Persons with Menta	met as evidenced by: view, the Group Home il Retardation (GHMRI ed to document a revie ures annually.	- }				
	The finding includes	5 :					
	and procedure man home revealed revid 11/20/2010 and 2/13	:46 a.m., review of the ual that was maintaine we dates of 9/1/2006, 2/2010. No additional	e policy ed in the		i 		
ith Regula TE FORM	tion Administration			_			
· ORIN	1		6409	· E	IYFV11	If continual	on sheet 3 of

Health F	Regulation Administra	ation				FORM	APPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MUL A. BUILD B. WING		(X3) DATE S COMPLI	
		HFD03-0044		_ii		09/2	4/2010
NAME OF F	PROVIDER OR SUPPLIER				, STATE, ZIP CODE		<u> </u>
СОММИ	NITY MULTI SERVICE	S, INC	5610 FIRST WASHINGT	ON, DC	7 NW 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
1 161	Continued From pa	ge 3		I 161	All staff will be trained on Individuals	diets	400040
	information was pre ended later that day	esented before the su /.	ırvey		food texture, BSP and proper docum of both bowel movements and BSP behaviors.		10/29/10
1 180	3508.1 ADMINISTR	ATIVE SUPPORT		1 180			
	Each GHMRP shall administrative supp- needs of the resider Habilitation plans.	provide adequate ort to efficiently meet nts as required by the	t the air				
	Based on observation review, the Group H Retardation (GHMR mental retardation p to meet residents' not be seen as the content of the content	met as evidenced by on, staff interview and lome for Persons wit P) failed to ensure quarofessional (QMRP) eeds, for three of the lity. [Residents #1, #	d record h Mental ualified services s four		QMRP will ensure all individuals recrecommended adaptive equipment a Client #2 receives an ambulating proall staff are trained on the ambulating	as well as otocol and	10/29/10
	The findings include	:					
	(Cross Reference ensure all staff recei implementation of Rirequirements, Residiplan and proper docibowel movements.	esident #3's food tex ent #1's behavior su	on the ture poort				
	2. [Cross Reference Citation W252] The (staff documented all observed maladaptiv	QMRP failed to ensu incidents of Residen	re that				
(3. [Cross Reference Citation W436] The (residents received the equipment.	QMRP failed to ensur	re all	; ;			
	4. [Cross Reference ensure all residents r	1055] The QMRP fail eceived their meals i	ed to in the				

Health F	Regulation Administra	<u>ation</u>				1 011	MALLIOVED
		(X1) PROVIDER/SUPPLIE (DENTIFICATION NUI		(X2) MULT A. BUILDI B. WING	***************************************	(X3) DATE SURVEY COMPLETED	
NAME OF F	PROVIDER OR SUPPLIER	111 111 111 111	STREET AN	DBESS CITY	STATE, ZIP CODE	09	/24/2010
COMMUNITY MULTI SERVICES INC. 56			5610 FIRS	ST STREET	`NW		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(K5) COMPLETE DATE
1 180	Continued From pa	ge 4		1 180			
	prescribed texture.						
	failed to ensure Res protocol was available	e [441] The facility's sident #2's ambulatio ble and presented to it implementation while ambulating.	n ali staff		!		
l 22 9	3510.5(f) STAFF TE	RAINING		1 229	Cross reference W159 #8		10/29/10
	Each training progra limited to, the follow	am shall include, but ing:	not be			<u> </u>	
	residents to be serv to, behavior manage	elated to the GHMRF ed including, but not ement, sexuality, nutr nmunications, and as	limited ition,				
	Based on observation review, the Group H Retardation (GHMR received training on Resident #1's behave Resident #2's gait be	met as evidenced by: on, staff interview and ome for Persons with P) failed to ensure all the implementation of ior support plan, use alt and Resident #3's ure, for three of the fo ity. [Resident #1]	n Mental I staff of of				
	The findings include:	;	•				
; ;	in-service trainings n approximately 2:55 p Resident #1's behavi offered on 2/26/2010 revealed that only fiv	422.2 Review of st ecord on 9/24/2010, a b.m., revealed that tra ior support plan (BSF). Further review, how e (5) out of the facility and staff had attended	at sining on ') was wever, y's ten				

Health H	legulation Administra	ation					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI HFD03-0044			(X2) MULT A. BUILDII B. WING		(X3) DATE SURVEY COMPLETED 09/24/2010		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS. CITY.	STATE, ZIP CODE	<u> </u>	24/2010
COMMU	NITY MULTI SERVICE	ES, INC	5610 FIRS WASHINGT	STREET	'NW		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
1229	Continued From pa	ge 5		1229	Cross reference W159 # 2		10/29/10
	on 9/24/2010 at app confirmed there we other than the 2/26/ confirmed what was 2/26/2010 BSP train	acility's house managoroximately 2:58 p.m re no other BSP train 2010 training. The I- s documented on the ning was true and a fi e staff that attended	lings held IM further				
	9/24/2010 at approx there was no docum the facility's ten (10)	a 1055] Record reviet dimately 2:45 p.m. re- nented evidence that a staff received trainir exture requirements	vealed any of no on	,			
	on 9/24/2010 at app confirmed none of the (10 staff) had receive modified food texture the HM also confirme	cility's house manage roximately 2:50 p.m. ne currently employed ed training on Reside e requirements. In a ed there was no addi ents on hand to revie	d staff ent #3's ddition, itional	;			
1	training on Resident	ensure all staff receiv #3's modified food te at his developmental	exture				
! : : : : : : : : : : : : : : : : : : :	peginning at 2:54 p.n powel movement (Bit support staff on each enter a zero if he had use a symbol listed in o document and des de Hard Stool (smal he BM charts reveals etaff falled to provide	1401.3] On 9/23/201 n., review of Residen M) charts revealed the shift were instructed in o BM during their shift below the scribe every BM. [Exill rocks)] Continued in ed numerous gaps with data from their shift, ring the past 3 month three shifts.	t #1's at direct I to shift or e chart ample: eview of here Failure				

Health Regulation Administration

10-15-2010

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TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPL IDENTIFICATION N		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		HFD03-0044		B. WING		09/24/2010	
AME OF F	ROVIDER OR SUPPLIER		STREET ADD	RESS CITY,	STATE, ZIP CODE	1 03/24/2010	
COMMUNITY MULTI SERVICES, INC			5610 FIRST WASHINGT	STREET	NW 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE	
1 229	Continued From page	ge 6		1 229			
	On 9/24/2010, at ap RN stated that she if on documenting res. The RN agreed to si support staff and to Nursing to request e by their nursing staff Review of staff in-se time later, beginning failed to show evider direct support staff a received training on Resident #1's BMs. was provided for reviater that afternoon. 3520.3 PROFESSIO PROVISIONS Professional services and evaluation, includevelopmental levels services, and serviced deterioration or further resident. This Statute is not make the Group Hore Retardation (GHMRF received timely medic services, for two of the facility. [Resident #1 received:	nad provided training idents' BMs on the Beek training records contact the Director evidence of training ref within the past 6 more reference training records at approximately 2: note that the facility's and the house manageroper documentation. No additional information before the surveille shall include both a ding identification of and needs, treatments designed to prevene loss of function by the tas evidenced by: no, interview and recomment for Persons with a proper for persons with a person pers	to staff M chart. for direct of eceived onths. s a short 55 p.m., nine (9) ger had on of ation y ended ERAL liagnosis ont the rd Mental sidents nursing ding in	401			
	Resident #1 received assessment, as follov					ĺ	

PRINTED: 10/06/2010

Health (Regulation Administr	ation			_		FORM	APPROVED
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU HFD03-0044		(X2) MU A BUIL! B, WIN	DING	E CONSTRUCTION	(X3) DATE : COMPL	ETED
NAME OF I	PROVIDER OR SUPPLIER	11. 000 0011	STREET AD	DRESS CIT	V CT	TE 7ID CORE	09/	2 4/20 10
	NITY MULTI SERVICI	ES, INC	5610 FIRS	ST STREE	ESS, CITY, STATE, ZIP CODE STREET NW ON, DC 20011			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLET	
1401	Continued From pa	age 7	į	J 401	1		· · · · · · · · · · · · · · · · · · ·	: -
	Resident #1's day particle that the resident while at the day progression assaultive said that was the record discomfort. The 9/22/2010, after the to have him evaluate returned to day progression recommunication recommunic	pproximately 11:50 a program activities coodent had hit himself a program on 9/20/2010 at worked with the residual had only seen the residual when he was "impacted ident's way to expression the stayed home agreed on 9/2 ted. [Note: The residual examination.] Reviewed from the home sical examination.] Reviewed from the head of the series of the end assess and bowels during the during the his BM habits on the series of 9/23/2010 do The ER discharge registed to show blook of the ER discharge registed to show blo	ordinator and others and dent sident sident see on 1/2010 ent eith no sident revealed the first of see dates et three estes et dates.					

Health f	Regulation Administra	ation				FURI	VI AFFROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:	(X2) MULT A. BUILDII B. WING		(X3) DATE COMP	SURVEY LETED
		HFD03-0044				09	/24/2010
NAME OF F	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY,	STATE, ZIP CODE		
COMMU	NITY MULTI SERVICE	s, Inc	5610 FIRS WASHING	T STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
1401	Continued From pa	~		1 401	Cross reference W331	7	11/2/10
	revealed no indicati procedures other th been performed at the	on that any diagnost an labs/blood in urin the hospital.	ic e had				[11210]
	a.m. revealed that " she had taken his vi	ne RN on 9/24/2010 a individual in no distre Ital signs. The entry, assessment of the re armed.	ess" and however.		: - 		
	Resident #1 was take evaluation on 9/24/2 p.m., which was 3 dexpressed concerns might be due to physical expressed.	ays after the day pro i that his assaultive b	ly 3:30 oram				
	It should be noted the BMs on the evening shift of 9/20/2010, evening shift of 9/22 shifts on 9/23/2010 at therefore, referred to Resident #1 was not	shift of 9/18/2010, e vening shift of 9/21/2 /2010 as well as the and 9/24/2010. Nurs o those BMs as evide	vening 010, morning ing staff.				
	2. The facility's nursi Resident #1 consiste as needed (PRN), in physician's orders (P	ently received stool s accordance with his	oftener	, par			
,	a. [Cross Reference Resident #1's day pressed concern repressed concern repressed concern repressed and the Review of Resident forders (POs) revealed was to receive "Milk foral suspension, gived ay as needed for configuration, beginning Resident #1's MARs	ogram activities coor e: the resident's bow potential for fecal im t's 9/2010 physiciar d that since 1/24/19 of Magnesia 400 mg 45 cc by mouth eve enstipation if no BM." at 2:54 p.m., review	rdinator rel paction. n's 94, he /5 ml rry 3rd On	1	·		

nealul r	<u>Regulation Administra</u>	ition					
		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE S COMPLI 09/2	
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, ST	TATE, ZIP CODE	1 00/2	772010
	NITY MULTI SERVICE	is, INC	5610 FIRS	T STREET N TON, DC 20	w		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETE DATE
I 401	that he had gone w 7/22/2010, 7/23/20 receiving the PRN I BM chart for 9/2010 on 9/6/2010, 9/7/20 documented having on 9/9/2010 (the 4tl accordance with the b. On 9/24/2010, at interview with the R medication nurse had been no BM, th MOM, as needed. review of the reside that the exact dates evening nurse had i every 3 days, begin evening nurse docuresident's BM chart review on 9/6/2010. review on 9/9/2010 missed a review on nurse(s) failed to do	ovement (BM) charts ithout a documented 10 and 7/24/2010 with Milk of Magnesia (MC) showed no docume 10 and 9/8/2010. A special administered MOM in day), which was no	BM on hout DM). The ented BM nurse at 7 p.m., evening review d if there nister the p.m., ealed he MAR he wed the d a en ning Resident	1401			
	again during the Eximental retardation porder was "if he goe however, was not coreads. They agreed from the PCP. 3. The facility's nurs	nat during the survey it conference, the qua- professional stated the 3 days without a Blonsistent with how the to seek further clarificing staff failed to ensconsistently documents follows:	alified at the M." This, e order ication				

Health F	Regulation Administra	ation					737710742
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL A BUILDING B WING	E CONSTRUCTION	(X3) DATE S COMPLE	
		HFD03-0044		B WING		09/2	4/2010
	PROVIDER OR SUPPLIER NITY MULTI SERVICE	ES, INC	5610 FIR	DORESS, CITY, ST ST STREET N' GTON, DC 200	W		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
	9/2010, revealed "congoing diagnosis, prune juice daily. T Magnesia 400 mg/s cc by mouth every constipation if no B at 2:54 p.m., review revealed that direct were instructed to eduring their shift or legend below the clevery BM. [Examp rocks)] Continued revealed numerous provide data from til	esident #1's POs date chronic constipation" He received Miralax he POs also included from the POS also	as an and d "Milk of give 45 or eginning charts h shift no BM n the I describe mall rts led to ocument				
	entries on 7/1/2010, 8/2/2010, 8/5/2010; 8/2/2010, 8/5/2010; b. 8 a.m 4 p.m. sh BM chart on 7/2/2017/19/2010, 7/22/2018/31/2010, 9/1/2010 and, c. 4 p.m 12 a.m. s entries on 7/31/2010 8/14/2010 and 8/15/00 9/24/2010, at ap RN stated that she hon documenting resi The RN agreed to se support staff and to Nursing to request e	nift - there was no da 10, 7/10/2010, 7/11/2 10, 7/23/2010, 8/6/20 1, 9/14/2010 and 9/23 hift - staff failed to m 0, 8/1/2010, 8/6/2010	ta on his 010, 10, 10, 1/2010; ake m., the to staff M chart. for direct of	The second secon			

Health R	egulation Administra	ation					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HFD03-0044		B. WING		09/2	24/2010
NAME OF D	ROVIDER OR SUPPLIER	111 202-2044	STREET ADD	DRESS, CITY, STAT	E. ZIP CODE	1 337.	<u> </u>
			l	T STREET NW			
COMMU	NITY MULTI SERVICI	es, inc 		TON, DC 20011			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
[401	Continued From pa	age 11		1 401			
	Review of staff in-s	service training record	ds a short				
	time later, beginning	ig at approximately 2	:55 p.m.,				
		ence that the facility's		ı			
		and the house mana		:			
	received training or	n proper documentat	ion of	•			
		. No additional inform					
		eview before the surv	ey ended	:			
	later that afternoon	l .		į			
	A. The facilitée aux	cion staff failed to an	euro that				
		sing staff failed to en ed on Resident #3's (:			
	orders were available "as needed."			1			
	CIGCIS WEIG STUNG	pio de ficcada.		!			
	On 9/23/2010, at 8	:59 a.m., while verify	ing the				
	morning medicatio	n pass observations,	Resident	•			
		"ProAir (Albuterol) Hi				•	
		inhale 2 puffs every 6		1			
		s indicated that the Al		ı			
		n 4/4/2008; however,					
	was no reason give	en for this PRN medic	cation. At				
		lication nurse looked		:			
		sinet twice and stated vailable. He suggest					
		valiable. ne suggest scontinued; however,					
		continue the medical		ŀ			
		i5 a.m., the recently-l					
		tardation professiona		•			
		ed they were not awa		:			
	reason why Reside	ent #3 might need to 1	use	ì	-		
	Albuterol. The QM	IRP immediately pres	sented a	1			
	Medical Assessme	ent dated 11/27/2009,	and upon				
		nat she saw no indica	itions for	2			
	the PRN medication	n.		•			
	On 0/24/2010 at a	pproximately 1:00 p.i	m the				
		stated that Albuterol v		4			
	typically prescribed	for treating asthma.	She	į			
	indicated that she	was previously unawa	are that	Ì			
		prescribed PRN on					
		lied "no" when asked					

Health Re	equiation Administra	ation				
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM HFD03-0044			(X2) MULTI A. BUILDIN B. WING _		(X3) DATE SURVEY COMPLETED 09/24/2010
NAME OF BE	ROVIDER OR SUPPLIER	111 200-0044	STREET AND	RESS CITY	STATE, ZIP CODE	0012-112-10
	IITY MULTI SERVICE	es, INC	5610 FIRS WASHINGT	T STREET	NW	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO GROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE COMPLETE
1 401	Continued From pa	ige 12		I 401		
	for it on the previou p.m., the RN indica informed her the Al back at the time it v presented a handw Albuterol, signed th There was no evide and medical team r with the medications prescri	ad informed her of his day. At approximal ted that the PCP had buterol had been need was ordered in 2008. Titten order to discontat day by the PCP, ence that the facility's reconciled physician's is-on-hand to ensure ibed for PRN use readen needed by the resident.	tely 2:20 I just eded only She then tinue the nurses orders that idily			
1 422	3521.3 HABILITAT	ION AND TRAINING		1 422		ŀ
	and assistance to re	l provide habilitation. esidents in accordan vidual Habilitation Pla	ce with			
	Based on observati review, the Group I- Retardation (GHMR training programs, to mealtime protocols interdisciplinary teal	met as evidenced by ion, interview and rec forme for Persons wit RP) failed to impleme behavior support plar as recommended by m, for two of the four lility. [Residents #1 a	ord h Mental nt is and the	į	·	
	The findings include:					
	Resident #1 (who is Staff #1 and stood i reached for the resi this was the residen that he needed to use resident was unable staff unfastened the	approximately 7:34 as non-verbal) walked in front of him. The st dent's belt while statint's means of informings the bathroom and a to undo the belt. Aft belt, the resident we bathroom. On 9/24/20	over to saff ng that ng him the er the ent		All staff will be trained on individual # goals. The management team will re documentation weekly and staff will r ongoing training on documentation fo goals.	iview IPP receive

Health R	egulation Administra	ation					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI HFD03-0044		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE S COMPL 09/2	
	ROVIDER OR SUPPLIER	111 500-504-7	STREET AND	RESS CITY ST	ATE, ZIP CODE	, , ,	
	NITY MULTI SERVICE	ES, INC	5610 FIRST	STREET NOON, DC 200	W		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
422	Support Plan, date had a training prog and unfasten his be should provide "verhim to unbuckle his that staff working w 9/23/2010 failed to the opportunity pre 2. [Cross Referent Citation W193.1] It consistently implement the evening of 9/23 observed hitting his vocalizing loudly. It direct support staff several times until Record review on \$12:05 p.m., reveale Support Plan (BSP that staff should "C choicephysically activitycreate a 's others continue to the entire situation another area or room he is Observations, how failed to offer Residonset, failed to phy activity, did not take room, and never eating in their effort to	of Resident #1's Individed 9/25/2009, revealed and 9/25/2009, revealed and prompts and end belt. The plan stated the balt prompts and end belt. Observations routh him on the morning implement his prograssented itself. The Federal Deficiency facility staff failed to be face and the face and the last attempted to the face and the last attempted to the repeated the bedinner was served. 10/24/2010, at approximated Resident #1's Behalt and the bedinner was served. 10/24/2010, at approximated Resident #1's Behalt and the bedinner was served. 10/24/2010, at approximated Resident #1's Behalt and the served and the second and the sec	idual d that he to fasten nat staff courage evealed ng of am when y Report SP. On vas i hit a ehaviors mately avior revealed er pression to srupting et him into from the nat staff from the nat staff from the nat onother to another to another to another one" for n and	1422	Cross reference W193		10/29/10
	aggression. Residing the dining room	ent #1 was allowed to the entire period he v hysically aggressive	o remain vas				

<u>nealul K</u>	equiation Administra	SIIUII					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIP A BUILDING B WING	LE CONSTRUCTION	(X3) DATE S COMPLI	
NA	ACIACE CO.	HFD03-0044	Datemen	DBESS COTT	TATE THE CORP	1 0312	-41EG 1G
NAME OF P	ROVIDER OR SUPPLIER		1		TATE, ZIP CODE		
COMMU	NITY MULTI SERVICI	ES, INC		ST STREET N STON, DC 20	· • =		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE 1E APPROPRIATE	(X5) COMPLETE DATE
1 422	Continued From pa	age 14		1422			
	3. Staff failed to implement a Resident #3's mealtime feeding protocol, as follows:						
	9/23/2010, at approstaff served Reside texture, but failed to "mechanically soft" care physician (PC 9/24/2010 at approprescribed he rece	i055] Observation or oximately 5:00 p.m. rent #3 his meal in a co ensure the meal was as prescribed by the P). Record review oximately 10:15 a.m. cent physician's orders ive a "mechanically signately signat	evealed shopped as served a primary in confirmed a (9/2010)				
	retardation profess approximately 6:10 have provided Res	acility's qualified menional (QMRP) on 9/2 p.m. confirmed staffident #3 with a "meclast prescribed by the	3/2010 at should hanically	!			
	and competency ne	alled to demonstrate acessary to ensure R meals in the texture p omental needs.	esident				
1 441	3521.7(k) HABILIT	ATION AND TRAINII	NG	1 441			
	The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:					,	
		ng ambulation, transp tation, and use of mo		; 1			
	Based on observati	met as evidenced by ion, staff interview an lome for Persons wit	d record	; ;			

Health H	legulation Administra	ation				,	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUMBER OF THE PROPERTY OF THE PROVIDER O		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/24/2010	
NAME OF P	ROVIDER OR SUPPLIER	111111111111111111111111111111111111111	STREET ADD	DRESS, CITY.	STATE, ZIP CODE	1 00.	
		to INC	5610 FIRS	T STREET	NW		
COMMO	NITY MULTI SERVICE	:5, INC	WASHING	TON, DC	20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOW CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
i 441	Continued From pa	ige 15		1441	Cross reference W159 #4		10/29/10
	sampled residents recommended ada their health and saf residents. [Residents]	ptive equipment to er lety for one of two sai nt #2]	nsure		:		
	The finding include	s:					
	12:15 p.m. revealed loosely secured gain helmet. The helme fitted and the gait be around his walst. It Resident #2's 1:1 nefacility) used his left Resident #2's gait be ambulate around the was observed he was observed he was earned at the same day at ap Resident #2 returned.	3/2010, at approximated Resident #2 was well to belt and a soft padout appeared to be project was loosely securified by the observation ursing staff (provided to hand to hold the right pelt as he assisted him is facility. On other olding to the back of walked behind him. proximately 4:20 p.med home from his day	earing a ded perly red n, d by the ht side of m to eccasions, Resident Later on		-		
	nurse and one of the under Resident #2's the stairs to the from attending nurse was the hold under Resident assisted him up the Record review on 9 revealed, Resident assessment dated that the facility "Corprotocol." Further resident assessment facility that the facility "Corprotocol."	ting the van, the atter te van staff each grates armpits and assistent door of the facility. Is then observed to coldent #2's left arm and stairs to his bedroom #24/2010 at 12:08 p.r #2's Physical Therap 08/03/2009 recommentinue [sic] ambulation record review and integalified mental retarda	obed od him up The ontinue d n. oy ended n				
	professional (QMRI approximately 3:00 documented eviden		was no otocol		!		. ,
		ent #2's habilitation r			!		

05:35:46 a.m.

10-15-2010

44 /44 8

Health R	equiation Administra	ation		,			
STATEMENT AND PLAN C	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER HFD03-0044 (X2) MULTIPLE CONSTRUCTION A. BUILDING B WING		COMPL	(X3) DATE SURVEY COMPLETED 09/24/2010		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
	NITY MULTI SERVICE	ES, INC	5610 FIRST	STREET NW ON, DC 2001	1	·	
(X4) ID PREFIX TAG	(FACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
441	Continued From pa	nge 16		1 441			
	The facility's QMRF ambulation protoco	document was not one faited to ensure the plant of the last second plant in plent in	oresented				
		•					
				Ì			
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